ADO 8/06 Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

COMPLETION OF ITEMS 1-9 BELOW ARE REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.104 AND KRS CHAPTER 205). YOU WILL RECEIVE THIS SECTION ANNUALLY TO UPDATE. PLEASE RETURN FORM TO:

KY Medicaid Provider Enrollment, P.O. Box 2110, Frankfort, Kentucky 40602-2110.

Note: See page 4 for definitions according to 42 CFR 455.101 and 455.104 and KRS Chapter 205.

_____

Provider Name/Entity Name

_____ _____

Provider Number NPI (National Provider Identifier)

1. List all current Medicaid provider numbers: [__][__][__][__][__][__][__][__][__] [__][__][__][__][__][__][__][__][__]

2. List all current Medicare provider numbers: [__][__][__][__][__][__][__][__][__][__]

3. If there has been a change in ownership, change of tax ID number (FEIN), or change in Kentucky Provider Number for a previously enrolled Kentucky Medicaid provider, please state previous provider number(s) and their effective date(s):

[__][__][__][__][__][__][__][__][__]	[__][__]	[__][__]	[__][__]	*to*	[__][__]	[__][__]	[__][__]
Previous Medicaid Provider. #	Mo.	Day	Yr.		Mo.	Day	Yr.
[__][__][__][__][__][__][__][__][__]	[__][__]	[__][__]	[__][__]	*to*	[__][__]	[__][__]	[__][__]
Previous Medicaid Provider. #	Mo.	Day	Yr.		Mo.	Day	Yr.

4. If you completed #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. Attach extra page if necessary.

_____

_____

5. If this facility is a subsidiary of a parent corporation, state corporate FEIN #: _____

Name: _____

Box or Address: _____

City: _____State:[____][____] Zip: _____-_____

6. List name, date of birth, SSN#/FEIN#, and address of each person or organization that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (N/A not acceptable.)

[__] **Check here if no one has 5% or more direct or indirect ownership, and skip to item #9.**

[__] **Check here if the information on the attachment is correct.**

7. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. Attach extra page if necessary.

NAME (a): _____ SSN: _____
-and/or-
Box or Address: _____ FEIN: _____

City: _____

State:[____][____] Zip: _____-_____

NAME (b): _____ SSN: _____
-and/or-
Box or Address: _____ FEIN: _____

City: _____

State:[____][____] Zip: _____-_____

8. If any individuals listed in item #7 (above) are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.)

Name: _____ Name: _____

Relationship: _____ Relationship: _____

SSN: _____ SSN: _____
-and/or- -and/or-
FEIN: _____ FEIN: _____

9. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs. (Attach extra page if necessary.)

NAME (a) NAME (b)

_____ _____

10. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state. (Attach extra page if necessary.)

NAME (a) NAME (b)

_____ _____

11. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting: If enrolled as an individual and you do not own a tax ID, please complete SSN only.

Report DMS payments to my FEIN: [__][__][__][__][__][__][__][__][__]
Report DMS payments to my SSN: [__][__][__][__][__][__][__][__][__]

12. Where do you want your Medicaid 1099 (annual earnings form) mailed?

Name:_____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

13. (_____)_____ **14.** Contact Name: _____
Telephone # **Ext.**

15. If you are an individual who can prescribe controlled substances please indicate your DEA (Drug Enforcement Agency) number. DEA Number_____

16. If you are a licensed PRTF (Psychiatric Residential Treatment Facility) please attach current attestation letter.

17. Please attach a listing of all KenPAC sites and current quotas.

18. If you are a Kentucky Medicaid group (more than one professional of the same provider type) please attach a listing of all professionals currently working in your group. Include the provider name; begin date with the group and the individual Kentucky Medicaid provider number.

19. Please attach a copy of your **W-9** form, "Request for Taxpayer Identification Number and Certification" **OR** a copy of your Social Security Card **OR** a notarized statement thereof.

20. If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected (KRS 205.510). Every health care provider, regardless of size, who creates or maintains individual protected health information in any form (written, oral or electronic) for the purpose of treatment, payment or care of operations of an individual and who also electronically transmits health information in connect with treatment, payment or operation – or who has someone else perform electronic billing on his behalf – is a covered entity and must comply with HIPAA's Privacy Rule. _____
[ ] I do not keep electronic medical records.

21. Email Address (optional): _____
NOTE: Your email address will not be given to any outside party for any reason. DMS may use provider email addresses to send provider letters/notices.

22. I certify that all the information I have provided on this Department for Medicaid Services Annual Disclosure Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program.

Signature: _____ Date Signed: _____

Title: _____ Witnessed By: _____

455.104 Definitions:

1. Indirect Ownership Interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
2. Other Disclosing Entity Means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII):
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishings of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

3. Person with an Ownership or Control Interest means a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership

4. Subcontractor means:

(a) An individual, agency, organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Please return form to:

KY Medicaid
Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST INSTURCTIONS

Field #	Description
1	List current Kentucky Medicaid provider numbers
2	List current Medicare provider numbers
3	If there has been a change of Federal Tax Identification number, please list previous Medicaid provider numbers and effective dates for each.
4	Describe relationship or similarities between the providers disclosing information on this form.
5	State Federal Tax Identification Number if there is an affiliation with a chain along with name, address, city, state and zip code.
6	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. If owner by a corporation attach sheet with officers and board members names and social security numbers. (N/A is not acceptable) Note: Do not send the list of board directors unless they own 5% or more. Indirect Ownership Interest-means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. Ownership interest-means the possession of equity in the capital, the stock, or the profits of the disclosing entity. Person with an ownership or control interest-means a person or corporation that: • Has an ownership interest totaling 5% or more in a disclosing entity • Has an indirect ownership interest equal to 5% or more in a disclosing entity • Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity • Is an officer or director of a disclosing entity that is organized as a corporation or • Is a partner in a disclosing entity that is organized as a partnership
7	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Subcontractor-means an individual, agency, or organization to which a disclosing entity have contracted or delegate some of it management functions or responsibilities of providing medicals care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies equipment or services provided under the Medicaid agreement.
8	If applicant is related to person listed in number 7 please list relationship.
9	List anyone with direct or indirect ownership whom has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state.
10	List any agent and/or managing employee who has been convicted of a criminal offense elated to any program established under Title XVIII, XIX, or II of the Social Security Act or any criminal offense in this state or any other state.

	Agent-means any person who has been delegated the authority to obligate or act on behalf of a provider. Managing Employee-means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
11	Please indicate which number you will be using for reporting monies paid to you from Medicaid for 1099 purposes. *Example: If you are an individual completing this question please input your Social Security Number unless you are a sole proprietor. A 64 provider can bill under his/her individual provider number even if they are working in a group setting. The individual must complete a MAP 347 in order to be linked to the group setting under which they are reporting.*
12	Enter the address you want your Medicaid 1099 mailed
13	Enter the telephone number of the contact person where the 1099's are mailed
14	Enter the name of the contact person where the 1099's are mailed
15	Enter the Drug Enforcement Agency number (DEA #)
16	Please attach your current attestation letter if you are a licensed PRTF (Psychiatric Residential Treatment Facility)
17	Please attach a listing of all KenPAC sites and current quotas.
18	Please attach a complete list of all professionals currently working in your group.
19	W-9 OR a copy of your Social Security Card OR a notarized statement thereof must be attached.
20	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
21	Enter E-mail address of applicant. (Optional)
22	Signature: enter original signature from the director, administrator, individual provider, owner, or authorized personnel. If you are an individual provider, *your* signature is required. Date: enter the date the agreement was signed Title: must be the title of person signing. EXAMPLE: administrator; doctor, etc. Witnessed By: Witness signature.